Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ST PAUL MEDICAL CENTER
PO BOX 201345
ARLINGTON TX 76006

Respondent Name

FIREMANS FUND INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-98-C081-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In accordance with the Texas Supreme Court decision invalidating TWCC rule 134.400; the Acute Care Inpatient Hospital Fee guideline, this billing is resubmitted for reevaluation of reimbursement." "We understand 100% reimbursement may not be appropriate and will discuss a reasonable settlement."

Amount in Dispute: $2124.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:

I. "Deficiency of Request.
II. Carrier's Supporting Documents.
III. Carrier's Justification for Payment Amount.
IV. Conclusion. The requester has failed to meet its burden to show that the reimbursement received was insufficient under the requirements of the Texas Labor Code. Therefore, Carrier requests a determination that the requester is not entitled to further reimbursement for the dates of service at issue."

Response Submitted by: Fireman's Fund Insurance Co., FOL, P.O. Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 1997 through October 15, 1997	Inpatient Hospital Services	$2124.39	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
3. This request for medical fee dispute resolution was received by the Division on May 5, 1998.
4. The services in dispute were reduced/denied by the respondent with the following reason codes.
   - D-Duplicate charge.
   - 226-Included in global charge.
   - 480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
   - 426-Reimbursed to fair and reasonable.
   - C-Negotiated contract.
   - G-Included in global.
   - F-Reduced according to fee guideline.
   - M-Reduced to fair and reasonable.

Findings

1. Review of the submitted explanation of benefits finds that the insurance carrier reduced or denied disputed services using code “C-Negotiated contract." 28 Texas Administrative Code §133.304(d), effective February 20, 1992, 17 *Texas Register* 1105, requires that "If the reductions in payment are limited to reductions by explicitly stated fee guideline or negotiated contract amounts, the insurance carrier shall stamp on the bill the following information, or submit a notice of medical payment dispute: "The reductions in payment are made according to the Texas Workers' Compensation Commission established fee guidelines (payment exception codes "F" or "B") or negotiated contract (payment exception code "C"). If you have questions contact: [name of auditor or adjuster] at [telephone number with area code]." Review of the submitted information finds no documentation to support that the insurance carrier submitted the required information to the provider. No documentation was found to support a contractual agreement between the parties to this dispute. The Division finds that the respondent has not met the requirements of §133.304(d). Therefore, the disputed services will be reviewed per applicable Division rules and fee guidelines.
2. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guidelin*e at 28 Texas Administrative Code §134.400, 17 *TexReg* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court’s opinion in *All Saints Health System v. Texas Workers’ Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission.”
3. The former Texas Workers’ Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
4. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include “copies of all written communications and memoranda relating to the dispute.” Review of the documentation submitted by the requestor finds that the request does not include any copies of explanation of benefits, medical records or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
5. Review of the submitted documentation finds that:
   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the

requestor states “In accordance with the Texas Supreme Court decision invalidating TWCC rule 134.400; the Acute Care Inpatient Hospital Fee guideline, this billing is resubmitted for reevaluation of reimbursement.” “We understand 100% reimbursement may not be appropriate and will discuss a reasonable settlement.”

- The Division finds that a reimbursement methodology based upon payment of a hospital’s billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital’s billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305(d). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	9/6/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.